

Public Employees Benefits Board (PEBB)

2003 Medical and Dental Coverage

- List all eligible family members and indicate their enrollment status on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

Are you making changes to an existing account? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of changes: (Check all that apply.)			
	<input type="checkbox"/> Name	<input type="checkbox"/> Address	<input type="checkbox"/> Medical plan	<input type="checkbox"/> Dental plan
	<input type="checkbox"/> Adding family member	<input type="checkbox"/> Re-enrollment	<input type="checkbox"/> Waiving coverage	<input type="checkbox"/> Termination

Section 1: Subscriber Information				
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address			Apt./unit number	
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)		
The medical plans marked with an asterisk* in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan or go to the Provider Directory on our Web site for code.			Physician name or clinic code	
Medical Coverage	<input type="checkbox"/> Enroll	<input type="checkbox"/> Waive: date effective _____	If waiving, see Section 6.	
Dental Coverage	<input type="checkbox"/> Enroll	(Dental may not be waived)	Note: You may not waive medical coverage for yourself and cover family members.	

Section 2: Spouse/Same-Sex Domestic Partner				
List your eligible spouse or same-sex domestic partner and indicate their enrollment status, even if you do not want coverage for them (see Section 6); they cannot be enrolled in any other PEBB coverage.				
Relationship to Subscriber		<input type="checkbox"/> Spouse: date of marriage _____		
If adding a spouse/partner, please attach a completed <i>Declaration of Marriage/Same-Sex Domestic Partnership</i> form.		<input type="checkbox"/> Same-sex domestic partner: date criteria met _____		
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (if different from subscriber)		City	State	ZIP Code
Date of birth (mm/dd/yyyy)	Physician name or clinic code (contact plan for code)			
Medical Coverage	<input type="checkbox"/> Enroll	<input type="checkbox"/> Waive: date effective _____	If waiving, see Section 6.	
Dental Coverage	<input type="checkbox"/> Enroll	<input type="checkbox"/> Waive: date effective _____		
Terminate Medical & Dental Coverage				
<input type="checkbox"/> Divorce/Dissolution of partnership: date of event _____				
Please provide his/her new address _____				
<input type="checkbox"/> Death: date of event _____				

Visit our Web site at www.pebb.hca.wa.gov

Agency Name	Agency/Subagency	Ins. Effective Date	Hire Date
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Section 3: Family Member Information (such as child, grandchild, etc.)

List all eligible family members and indicate their enrollment status, even if you do not want coverage for them (see Section 6); family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.**

A	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician name or clinic code (contact your plan for code)			
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)		City	State	ZIP Code	
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 6.</i>		<input type="checkbox"/> Terminate due to loss of eligibility Reason _____ Date effective _____			

B	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician name or clinic code (contact your plan for code)			
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)		City	State	ZIP Code	
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 6.</i>		<input type="checkbox"/> Terminate due to loss of eligibility Reason _____ Date effective _____			

C	Relationship to subscriber	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student? (Check only if age 20 or older.)	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician name or clinic code (contact your plan for code)			
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)		City	State	ZIP Code	
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 6.</i>		<input type="checkbox"/> Terminate due to loss of eligibility Reason _____ Date effective _____			

Section 4: Medical Plan Selection (Check only one.)

- | | |
|---|---|
| <input type="checkbox"/> Group Health Cooperative of Puget Sound | <input type="checkbox"/> Premera Blue Cross |
| <input type="checkbox"/> Group Health Options, Inc. | <input type="checkbox"/> RegenceCare* |
| <input type="checkbox"/> Kaiser Foundation Health Plan of the Northwest | <input type="checkbox"/> Uniform Medical Plan |
| <input type="checkbox"/> PacifiCare of Washington, Inc.* | |

**These plans require the physician name or clinic code of your selected primary care provider. Contact the plan for code or go online to www.pebb.hca.wa.gov for provider directories.*

Section 5: Dental Plan Selection (Check only one.)**Preferred Provider Organization**

- (may receive services from any provider)
- ☐ Uniform Dental Plan (Group #3000)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Managed Care Plans

- ☐ DeltaCare (Group #3100) (must receive services from *DeltaCare provider*)
Dentist name or clinic code _____
- ☐ Regence BlueShield Columbia Dental Plan (must receive services from *Columbia Dental Group provider*)
Clinic location _____

Section 6: Signature (Required)

I certify that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage.

I certify that I or any of my family members who have chosen to waive medical/dental coverage, as indicated above, currently have other continuous, comprehensive medical/dental insurance. I understand that proof of continuous, comprehensive medical/dental coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 31 days of losing other coverage.

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Subscriber's signature _____ Date _____

Please sign and date this form. Return completed form to your Payroll or Insurance Office.